HEALTH HISTORY MUST BE COMPLETED FOR ATTENDANCE

PLEASE COMPLETE THIS FORM AND MAIL AS SOON AS POSSIBLE TO: →

Bill Fannin
141 Cinderella Dr.
Owensboro, KY 42303

(No information provided herein shall be released, as it is exempt under the provision of the Open Records Act. See KRS 61.878.)

Camper's name _____ Date of birth _____ County _____

Give approximate dates (except for allergies) of all that apply.

Diseases

_____ Frequent Ear Infections
_____ Heart Defect/Disease
_____ Convulsions
_____ Diabetes
_____ Bleeding/Clotting Disorders
_____ Hypertension
_____ Mononucleosis
_____ Psychiatric Treatment
_____ Chicken Pox
_____ Measles
_____ German Measles
_____ Mumps
Other (specify) _____
_____
_____
_____

Allergies

☐ Hay Fever
☐ Ivy Poisoning, etc.
☐ Insect Stings
☐ Penicillin
☐ Other Drugs
☐ Asthma
☐ Other (specify)
_____

Current medications **(send in labeled container with instructions)** _____

_____

Operations or serious injuries? ☐ Yes ☐ No _____
Disability or chronic or recurring illness? ☐ Yes ☐ No _____
Activities encouraged or limited by physician? ☐ Yes ☐ No _____
Dietary modifications? ☐ Yes ☐ No _____
Psychiatric counseling or hospitalization? ☐ Yes ☐ No _____
Other diseases or details of above _____

_____

Date of last Tetanus Vaccine _____ Date of last physical examination _____
Name of dentist/orthodontist _____ Phone _____
Name of family physician _____ Phone _____
Name of Camper's Health Insurance Provider _____ Phone _____
Name of Policyholder _____ Phone _____

*** Restrictions may apply to camp insurance. Camp insurance does not cover pre-existing conditions.**

This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed camp activities except as noted. Authorization for Treatment: I hereby give permission to the medical personnel selected by the camp director to order X-rays, routine tests, treatment, and necessary transportation for my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to secure and administer treatment, including hospitalization, for my child as named above. The completed forms may be photocopied for trips out of camp. I hereby give permission for my child to be administered prescription and non-prescription medication as needed unless otherwise noted. I also hereby give permission for pictures to be taken of my child during camp and I understand that they may be used for future promotional purposes. I hereby certify that all information provided herein is true, accurate and complete. If I have failed to provide or have withheld information or have provided inaccurate responses, I understand that the application will be rejected and any deposit will not be returned.

Signature of Parent or Guardian _____

Print Parent or Guardian Name _____ **Date** _____